Fifty-two percent were hospitalized during the last 2 years. Due to cost, 9% had a specific medical problem but did not visit a doctor and 9% skipped or did not get a medical test, treatment, or follow-up, recommended by a doctor. The respondent with family spent on average 667;- € (highest in UK: 1.357,- €) on medical treatment not covered by insurance. **CONCLUSIONS:** These interim survey results point to a patient population (SPAF) under challenging conditions requiring numerous resources. Future research with extended respondent numbers needs to be analyzed to allow robust and clear recommendations.

PCV113

PATIENT SATISFACTION WITH STROKE PREVENTION IN ATRIAL FIBRILLATION – MEDICAL-DRIVEN INTERIM RESULTS OF A EUROPEAN SURVEY

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OBJECTIVES: To evaluate and compare patient satisfaction with stroke prevention in atrial fibrillation (SPAF) in Europe. Secondary objective is to investigate and compare the influence of health care systems on patient satisfaction. Interim results are presented to initiate discussions and guide analysis for the main survey. **METHODS:** A survey based on the Commonwealth Fund Survey (2008) for chronically ill adults is applied to patients with SPAF, with few disease-specific adjustments made. The survey is carried out with structured randomized anonymous telephone interviews in France, Germany, Italy, Spain and UK, screening for respondents with AF aged over 18. Total pilot sample size is 152 respondents, evenly divided per country. **RESULTS:** The pilot results indicate differences to other chronically ill patients as well as country variations. Mean age of respondents was 67, 50% were female. For 12%, test results, medical records, or reasons for referrals, were not available at the time of their scheduled doctor's appointment. Twenty percent had doctors recommending treatment that the respondents thought had little or no health benefit. 30% felt often or sometimes during the past 2 years that their time was wasted because of poorly organized medical care. 35% had a doctor who sometimes, rarely or never encouraged them to ask questions. 29% had a doctor who sometimes, rarely or never gave them clear instructions about symptoms and when to seek further care or treatment. 39% of the respondents had sometimes, rarely or never (21%) a regular doctor or someone in their doctor's practice to help coordinating or arrange the care they received from other doctors and places. **CONCLUSIONS:** The interim survey results implicates that there is room for improvement of the health care systems, the organization of medical care and for communication. Future research with extended respondent numbers needs to be analyzed to allow robust and clearer recommendations.

PCV114

PREFERENCES FOR COMMUNICATION OUTCOMES FOLLOWING A STROKE

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OBJECTIVES: Communication impairment after stroke has wide-ranging impacts on everyday activities and social participation. Following stroke, there are waiting lists of upto 6 months for National Health Service (NHS) speech and language therapy (SLT). Objectives were to estimate the willingness of participants to wait for SLT for communication impairment. **METHODS:** A binary, forced choice, discrete choice experiment (DCE) measured preferences. Attributes, levels and descriptions were derived from COAST, a validated communication impairment specific measure developed with service users. Factor analysis and expert review identified four (5-level) items for the DCE (impact of communication impairment on: social/family life; involvement in interests/hobbies; daily activities; worry and unhappiness; waiting time). A fractional factorial design and modulo arithmetic identified 25 choice sets. A random sample of 4000 members of the general public was invited to participate by post. The design had 89% efficiency for a linear additive, main effects model, with all five attributes. **RESULTS:** A total of 278/4000 people participated. All the attributes were important contributors to the preferences of participants ($p<0.01$). Ability to communicate with family and friends was the most important attribute. Participants were willing to wait longer than 6 months for improvements (8-37 months) in each attribute. Participant characteristics did not affect the results. **CONCLUSIONS:** Participants may be willing to wait longer than one year for treatment that improves their ability to communicate and the impact that this has on their lives. This is longer than the maximum waiting time included in the survey, and questions government policy to target waiting times to improve health care. Younger people are willing to wait for longer for therapy than older people. A number of assumptions were made in the design and conduct of the DCE survey. Combined with the low response rate (7%), the results are only indicative of preferences. Further surveys are merited.

PCV115

THE SENSITIVITY OF PRO'S IN EVALUATING ADVERSE EVENTS IN PEOPLE RECEIVING "STATIN" THERAPY

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OBJECTIVES: To investigate whether patient reported outcomes could detect adverse event differences between cholesterol lowering agents "statins" and patients could recall enough information to assess the differences. **METHODS:** In this evaluation, PROBE (patient reported outcomes based evaluation) methodology consisting of a web-based system supplemented by telephone reporting was used to collect naturalistic data from people who were taking or about to start "statin" therapy. People were recruited through internet pay per click advertising, social networking sites and search engine optimisation. Data collection was a one off questionnaire. Data included baseline demographics, therapy name, dose, cholesterol level before and after treatment, any side effects and action taken in response to side effect. **RESULTS:** A total of 679 recipients participated in the evaluation. 49% of participants were male with 43% aged between 41-60 and 52% between 61 -80. Overall, 336 (52%) of respondents felt they had experienced a side effect since commencing "statin" therapy with an average of 5 side effects per person. 121 (18%) people reported that they required treatment with respect to the side effect, the commonest report being muscle pain in the arms or legs (28% of patients accounting for 39% of all side effects). Interestingly, 24% of people on atorvastatin (mean dose 26mg) required treatment in relation to their side effect(s) as compared to 19% on simvastatin (mean dose 29mg). 64% of people could recall their cholesterol before starting therapy and 94% supplied a meaningful figure. **CONCLUSIONS:** This evaluation shows that the PROBE methodology quickly and simply captured patient reported outcome information on adverse events and patient actions in a population taking cholesterol lowering therapy. Half the population receiving "statins" reported a side effect and 18% required a medical intervention in relation to their side effect(s).

PCV116

THE IMPACT OF HIGH RISK OF STROKE PATIENTS DIAGNOSED WITH ATRIAL FIBRILLATION ON HEALTH-RELATED QUALITY OF LIFE, AND HEALTH CARE USE IN 5EU

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OBJECTIVES: This study investigates stroke risk and the association with health-related quality of life (HRQoL), and resource use among diagnosed atrial fibrillation (AF) patients. **METHODS:** The study included data from the EU 2010 (N=57,805) National Health and Wellness Survey, a self-administered, internet-based questionnaire from a demographically representative sample of adults (aged ≥18) in 5EU. Stroke risk was assessed with CHA2DS2-VASc, an index summing the presence of congestive heart failure, hypertension, age ≥ 75 (2 points), diabetes mellitus, previous stroke/transient ischemic attack (2 points), vascular disease, age 65-74, and female gender. Low- (CHA2DS2-VASc = 0), moderate- (1), and high- (2+) risk patients reported on measures of HRQoL (mental (MCS), physical component summary (PCS) and SF-6D (health utility) scores from the SF-12v2), and health care resource use. **RESULTS:** Among 479 diagnosed AF respondents (prevalence of 0.93%), 15.1% were low, 27.9% moderate, and 57.0% high risk for stroke. Significant differences exist in the use of anticoagulant medication for stroke prevention among low- (38.9%) vs. moderate- (54.9%), and high- (59.8%) risk patients, $p<0.05$. High-risk patients reported significantly lower levels of HRQoL relative to low-risk patients (PCS: 37.1 vs. 41.3; Utilities: 0.65 vs. 0.70, $p<.05$). The number of hospitalizations and physician visits in the past 6 months were also significantly higher for high-risk patients compared with both low-risk and moderate-risk patients (hospitalization: high- (0.43) vs. moderate- (0.26) and low-risk (0.14), $p<0.05$) **CONCLUSIONS:** In 5EU, 40% of AF patients at high-risk of stroke are not taking anticoagulant medication. Being high-risk for stroke can be a substantial burden on AF patients, reducing their HRQoL, after accounting for demographics, patient characteristics, and comorbidities. Increased number of hospitalizations and physician visits suggests that these AF patients can place a substantial burden on the healthcare system. There remains an unmet need for enhanced treatment of high-risk AF patients.

PCV117

CLINICAL AND PATIENT-REPORTED OUTCOMES OF TRIPLE COMBINATION OF OLMESARTAN MEDOXOMIL (OM), AMLODIPINE BESYLATE (AML) AND HYDROCHLOROTHIAZIDE (HCT) IN HYPERTENSIVE PATIENTS

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OBJECTIVES: To compare clinical and patient-reported outcomes of OM/AML/HCT triple combination of different dose strengths with that of respective double combination in hypertensive patients. **METHODS:** The study (CS8635-A-E302) was a randomised, double-blind, parallel-group study, multi-centre, European, phase III clinical trial evaluating the efficacy and safety of co-administration of triple combinations OM/AML/HCT directly compared with the corresponding double combination of OM/AML in subjects with hypertension. The following five pairwise treatment group comparisons were considered after 10 weeks: A) OM20/AML5/HCT12.5mg vs. OM20/AML5; B) OM40/AML5/HCT12.5mg vs. OM40/AML5; C) OM40/AML5/HCT25mg vs. OM40/AML5; D) OM40/AML10/HCT12.5mg vs. OM40/AML10; E) OM40/AML10/HCT25mg vs. OM40/AML10. Primary clinical outcome was the responder rate defined as percentage of subjects achieving blood pressure goal (<140/90 mmHg; <130/80 mmHg for subjects with diabetes, chronic renal disease, or chronic cardiovascular disease). The number-needed-to-treat (NNT) was calculated. Patient reported outcomes (PRO) were recorded on two quality-of-life (QoL) instruments, EQ-5D and MINICHAL. **RESULTS:** Overall, 2690 patients (mean age: 56.5±10.5 years; 53.6% female) were followed over 10 weeks, balanced in each treatment group. Responder rate was higher in triple treatment groups compared to respective dual combination: A) 53.0% versus 42.7%, $p<0.05$, NNT 10 patients; B) 52.4% versus 46.4%, NNT 17 patients; C) 58.8% versus 46.4%, $p<0.05$, NNT 9 patients; D) 56.5% versus 49.6%, NNT 15 patients; E) 53.9% versus 49.6%, NNT 23 patients. Whereas patients reported statistically significant intra-individual improvements for most of the treatment regimens (mean improvement ranged from 0.007 to 0.026 (EQ-5D utility score) and from -1.2 to -1.7 (MINICHAL), the 10-week change in QoL was not significantly different between treatment groups of triple and the respective dual combination. **CONCLUSIONS:** Overall, responder rates are superior in patients receiving triple combination OM/AML/HCT in comparison to the respective dual combination OM/AML. Although the triple combination contains a further agent this had no negative impact on QoL.